Supreme Court, U.S.
FILED

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OFFICE OF THE CLERK

No._____

IN THE

Supreme Court of the United States

OCTOBER, TERM, 1997

BLUE CROSS AND BLUE SHIELD OF MICHIGAN,

Petitioner,

vs.

BPS CLINICAL LABORATORIES, et al.,

Respondents.

ON PETITION FOR WRIT OF CERTIORARI TO THE SUPREME COURT AND COURT OF APPEALS OF THE STATE OF MICHIGAN

APPENDIX TO PETITION FOR WRIT OF CERTIORARI TO THE SUPREME COURT AND COURT OF APPEALS OF THE STATE OF MICHIGAN

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Appendix A

MICHIGAN SUPREME COURT
LANSING, MICHIGAN

ORDER
Entered: October 21, 1997

107913 & (56)
107914 & (41)
107915 & (43)
107922 & (54)
107923 & (39)
107924 & (41)

Conrad L. Mallett, Jr.
Chief Justice
James H. Brickley
Michael F. Cavanagh
Patricia J. Boyle
Elizabeth A. Weaver
Marilyn Kelly
Clifford W. Taylor
Justices

BPS CLINICAL LABORATORIES, MICHIGAN CLINICAL LABORATORY, MML, INC., MBL LABORATORIES, FLINT MEDICAL LABORATORY, ALLIED MEDICAL LABORATORY-FLINT, INC., WILLIAM E. BLAMEY, D.O., MID-MICHIGAN PATHOLOGY SERVICES, P.C., and UNIVERSAL STANDARD MEDICAL LABORATORIES, INC.,
Plaintiffs-Appellees, Cross-Appellants,

v.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN,
Defendant-Appellant, Cross-Appellee.

SC: 107913, 107914, 107915, 107922, 107923, 107924
COA: 187107, 108708, 108709
LC: 91-107952-CK

BPS CLINICAL LABORATORIES, MICHIGAN CLINICAL LABORATORY, MML, INC., MBL LABORATORIES, FLINT MEDICAL LABORATORY, ALLIED MEDICAL LABORATORY-FLINT, INC., WILLIAM E. BLAMEY, D.O., MID-MICHIGAN PATHOLOGY SERVICES, P.C., and UNIVERSAL STANDARD MEDICAL LABORATORIES, INC.
Plaintiffs-Appellants, Cross-Appellees,

v.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN,
Defendant-Appellee, Cross-Appellant.

Appendix A

On order of the Court, the application for leave to appeal and the application for leave to appeal as cross-appellant are considered. The application for leave to appeal is DENIED, because we are not persuaded that the question presented should be reviewed by this Court. The application for leave to appeal as cross-appellant is therefore moot and is DENIED. The motion to file a brief amicus curiae is GRANTED. The motion to strike is DENIED.

Cavanagh, Boyle and Kelly, JJ., would grant leave to appeal.

I, CORBIN R. DAVIS, Clerk of the Michigan Supreme Court, certify that the foregoing is a true and complete copy of the order entered at the direction of the Court.

/s/ CORBIN R. DAVIS

CORBIN R. DAVIS
CLERK

October 21, 1997

Appendix B

STATE OF MICHIGAN
COURT OF APPEALS

BPS CLINICAL LABORATORIES; MICHIGAN CLINICAL LABORATORY, MML, INC.; MBL LABORATORIES; FLINT MEDICAL LABORATORY; ALLIED MEDICAL LABORATORY-FLINT; WILLIAM E. BLAMEY, D.O.; MID-MICHIGAN PATHOLOGY SE; AND UNIVERSAL STANDARD MEDICAL LABORATORIES, INC.,
Plaintiffs-Appellants/ Cross-Appellees.

v.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN, a non-profit health care corporation,
Defendant-Appellee/ Cross-Appellant.

FOR PUBLICATION
July 26, 1996
9:00 a.m.

Nos. 187107, 187108, 187109
LC No. 91-107952-CK

ON REMAND

Before: Doctoroff, C.J. and Michael J. Kelly and White, JJ.

PER CURIAM.

We consider this case on remand from our Supreme Court for reconsideration in light of *New York State Conference of Blue Cross & Blue Shield v. Traveler's Ins. Co.*, 514 US __; 115 S Ct 1671; 131 L Ed 2d 695 (1995). We affirm in part and reverse in part.

Appendix B

In *BPS Labs v Blue Cross*, 206 Mich App 570 (1994), we considered plaintiffs' claims that defendant wrongfully denied them the opportunity to participate in its new health care program in violation of state law. We held that plaintiffs' claims were preempted by the federal Employee Retirement Income Security Act (ERISA), 29 USC 1001 *et seq.* Subsequent to the publication of our case, the United States Supreme Court decided *New York Blue Cross, supra.* In light of *New York Blue Cross*, we repudiate our prior decision and hold that ERISA does not preempt plaintiffs' claims under state law.

I

This case involves defendant's Premier Prudent Laboratory Use program (Premier Plus), which defendant administers for General Motors Corporation under an "administrative services only" contract. This contract requires General Motors to pay defendant a fee for administering the program and reimburse defendant for all covered health care charges paid by defendant on behalf of program employees. Defendant does not function as an insurer for program enrollees.

Under Premier Plus, defendant created a panel of six provider laboratories that agreed to discount the rate for laboratory services. Physicians who referred laboratory services to the provider laboratories would receive a $3 blood handling fee from defendant. Physicians who referred specimens to non-panel laboratories would not receive the fee. While the panel of provider laboratories would receive the full discounted rate from defendant, non-panel laboratories would only receive fifty percent of the maximum payment schedule.

Plaintiffs are health care providers excluded from full reimbursement under Premier Plus. Plaintiffs filed two different suits,

claiming several violations of state law. First, plaintiffs alleged that Premier Plus violated the Michigan Nonprofit Health Care Corporation Reform Act (Act 350). MCL 550.1101 *et seq*; MSA 24.660(1101) *et seq*. Second, plaintiffs argued for mandamus relief ordering defendant to comply with the Prudent Purchaser Act (PPA), MCL 550.51 *et seq*; MSA 24.650 *et seq*. Third, plaintiffs claimed that the plan constituted a breach of contract. Fourth, plaintiffs maintained that the creation of Premier Plus resulted in a tortious interference with a business relationship. Fifth, plaintiffs alleged that Premier Plus violated the Michigan Antitrust Reform Act. MCL 445.772; MSA 28.70(2). Defendant maintained that plaintiffs' claims were preempted by ERISA.

Defendant filed a motion for summary disposition pursuant to MCR 2.116(C)(8) and (10). The trial court granted defendant's motion for summary disposition on all of defendant's claims except for the alleged violation of the PPA. In *BPS Labs v Blue Cross, supra*, we affirmed in part and reversed in part, holding that ERISA preempted plaintiffs' state claims.

II

ERISA § 514(a) provides that ERISA "shall supersede any and all State laws insofar as they . . . relate to any covered employee benefit plan." 29 USC 1144(a). In *New York Blue Cross*, the U.S. Supreme Court stated that the term "relate to" was so vague as to be meaningless. The Supreme Court held that the basic thrust of ERISA's preemption clause was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans. State laws which force an ERISA plan administrator to modify a benefit plan in order to comply with the laws of a specific state would violate ERISA. *Id.* at 131 L Ed 2d 695, 706.

Appendix B

The PPA does not preclude the nationally uniform administration of employee benefit plans. The PPA was enacted to address the problem of rising health care costs in Michigan. The drafters of this legislation determined that few incentives existed in the health care marketplace to contain costs. In an attempt to encourage insurance companies and nonprofit health care corporations to contain costs, the PPA permits these organizations to enter into prudent purchaser agreements with a limited number of health care providers selected on the basis of cost of services and quality of care. These organizations could then encourage or require consumers to utilize the selected health care providers. House Legislative Analysis. HB 4799-4801, 5067-5069 (January 8, 1985).

The PPA permits certain organizations to *voluntarily* enter into prudent purchaser agreements with health care providers to control health care costs. MCL 550.53(1); MSA 24.650(53). Because the PPA does not mandate that any party enter into a prudent purchaser agreement, we hold that the Prudent Purchaser Act, MCL 550.51 *et seq*; MSA 24.650(51) *et seq* is not preempted by ERISA. When a state passes a law which requires all employee benefit plans to pay pregnancy-related benefits to employees, then a benefit provider must alter the plan to comply with a specific state law. *Shaw v Delta Airlines Inc.*, 463 US 85, 97; 103 S Ct 2890; 77 L Ed 2d 490 (1983). Similarly, when a state mandates that an employee benefit plan provide minimum mental health coverage, then a plan administrator must modify the plan or violate state law. *Metropolitan Life Ins. Co v Massachusetts*, 471 US 724, 740; 105 S Ct 2380; 85 L Ed 2d 728 (1985). In those cases, ERISA preemption permitted the nationally uniform administration of employee benefit plans. However, we fail to see how a statute that only applies to those who choose to fall within its purview could preclude the nationally uniform

administration of employee benefit plans. Unlike *Shaw* and *Metropolitan Life*, the PPA did not mandate any change in health care coverage or the administration in benefits. The act only imposed certain requirements once defendant chose to form prudent purchaser agreements. Because we find that the PPA does not preclude the nationally uniform administration of employee benefit plans, we hold that plaintiffs' claims pursuant to the PPA are not preempted by ERISA.

We also hold that ERISA does not preempt plaintiffs' claims under the Michigan Nonprofit Health Care Corporation Reform Act (Act 350). MCL 550.1101 *et seq*; MSA 24.660(1101) *et seq*. Plaintiffs alleged that defendant violated Act 350 by (1) failing to submit a revised certificate to the Insurance Commissioner for rate approval of Premier Plus, (2) failing to submit a list defining the provider class plans to the Insurance Commissioner, and (3) using money to induce referring physicians to work with panel laboratories. Defendant argued that ERISA preempted the procedural requirements of Act 350 because the imposition of these requirements would preclude the nationally uniform administration of employee benefit plans.

The Michigan Nonprofit Health Care Corporation Reform Act is the enabling legislation for defendant. The primary purpose of the original act was to promote a wider distribution of medical care to those people who otherwise did not have the financial resources to obtain health care services. The secondary purpose was to protect the public from fraud by placing the health care corporations charged with administering the plans under the regulatory authority of the Commissioner of Insurance. Act 350 modified the earlier enabling legislation so that the Insurance Commissioner would possess the power to require specific cost-containment procedures. Defendant participated in the development of the legislation. *BCBSM v Governor*, 422 Mich 1,

14-17; 367 NW2d 1 (1985). The Act provides that a health care corporation shall offer health care benefits to all residents of the state who apply for such benefits. MCL 550.1202(1)(d); MSA 24.660(1202)(1)(d). MCL 550.1401(1); MSA 24.660(1401)(1)(d).

Requiring defendant to comply with the requirements of its enabling legislation does not preclude the nationally uniform administration of benefit plans.[1] Defendant asks this Court to cast off the procedural requirements of its enabling legislation because they add a burden to its administration of health care plans but to retain its exemptions from state tax and corporate law. Taking defendant's argument to its logical conclusion, the state would lose any ability to regulate defendant at all. As the Supreme Court stated in *New York Blue Cross*:

> [w]hile Congress's extension of pre-emption to all 'state laws relating to benefit plans' was meant to sweep more broadly than 'state laws dealing with the subject matters covered by ERISA[,] reporting disclosure, fiduciary responsibility, and the like,' [citations omitted], nothing in the language of the Act or the context of its passage indicates that Congress chose to displace general health care regulation, which has historically been a matter of local concern. [*Id*, at 131 L Ed 2d 695, 709.]

The fact that ERISA does not address the relationship of a benefit plan with health care providers supports our conclusion. Because we do not agree that Congress intended to preempt state law where no federal regulation exists to replace it, we find that none of plaintiffs' claims are preempted by ERISA. *International Resources v New York Life Ins.*, 950 F 2d 294, 298 (CA 6, 1991).

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[1] The plan's self-insured status has no effect on our analysis. *Travelers Ins. Co. v Pataki*, 63 F 3d 89, 93 (CA 2, 1995).

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ERISA was enacted to protect the pension funds of employees and beneficiaries. The stated policy of ERISA is "to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries." 29 USC 1001(b). While participants, fiduciaries, beneficiaries, or government entities are entitled to file a civil action under ERISA, health care providers under contract with the plan administrator have no standing to file a civil action. 29 USC 1132.

As the Eleventh Circuit stated in *Lordmann Enterprises, Inc. v Equicor, Inc:*

> Preemption in a third-party health care provider case would defeat rather than promote the goal of ERISA. The commercial realities of the health care industry require that health care providers be able to rely on insurer's representations as to coverage. If ERISA preempts their potential causes of action, health care providers could no longer rely on the insurer's representation and must either deny care or raise fees to protect themselves against the risk of non-coverage. In that event, the employees who were protected by ERISA would find medical treatment more difficult to obtain. [*Id.* at 32 F 3d 1529, 1533 (CA 11, 1994)].

III

Having determined that ERISA does not preempt plaintiffs' claims, we now address the trial court's disposition of the case. The trial court granted defendant's motion for summary disposition pursuant to MCR 2.116(8) and (10) on all of plaintiffs' claims except for the claimed violation of the PPA. MCL 550.51 *et seq*; MSA 24.650 *et seq*. The trial court determined that defendant had violated the PPA. We review de

novo a trial court's grant or denial of a motion for summary disposition. *Thomas v Bd of Law Exam'rs*, 210 Mich App 279, 280; 533 NW2d 3 (1995).

First, we find that the trial court did not err when it granted defendant's motion for summary disposition on plaintiffs' claim of a violation of Act 350. The trial court correctly held that Act 350 does not grant a health care provider the right to sue a health care corporation directly. Only the Attorney General and the Insurance Commissioner are entitled to enforce the act directly against the health care corporation. MCL 550.1619(2)(3); MSA 24.660(619)(2)(3). Additionally, a person seeking to compel compliance with, or enforcement of, the act has a right to bring an action in the Ingham Circuit Court to compel the commissioner to enforce the act. MCL 550.1619(3). The only private right of action directly against the health care corporation authorized by the act is an action by a subscriber against the health care corporation for damages. MCL 550.1402(11); MSA 24.660(402)(11). Because this statute only explicitly allows a private right of action by a subscriber, we conclude that no other private rights of action directly against the health care corporation are authorized. *See Williams v Coleman*, 194 Mich App 606, 613; 488 NW2d 464 (1992). The relief sought by plaintiffs regarding the enforcement of Act 350 is available through the procedure set forth in MCL 550.1914(3). Plaintiffs may commence an action in the Ingham Circuit Court to compel the Insurance Commissioner to enforce the act.

Next, we find that the trial court properly dismissed plaintiffs' claims of tortious interference in a business relationship. The elements of tortious interference with a business relationship are the existence of a valid business relationship or expectancy on the part of the interferer, an intentional interference inducing or causing a breach or termination of the relationship or expectancy,

and resultant damage to the party whose relationship has been disrupted. *Lakeshore Hosp v Perry*, 212 Mich App 396, 401; 538 NW2d 24 (1995). To establish that a lawful act was done with malice and without justification, the plaintiff must demonstrate, with specificity, affirmative acts by the interferer which corroborate the improper motive of the interference. *Feldman v Green*, 138 Mich App 360, 369; 360 NW2d 881 (1984). Where the defendant's actions were motivated by legitimate business reasons, its actions would not constitute "improper motive or interference." *Podiatric Ass'n v Nat'l Foot Care*, 175 Mich App 723, 736 (1989). Because we agree with the trial court that defendant established Premier Plus for a legitimate business purpose, plaintiffs' claim of tortious interference with a business relationship was without merit.

Third, we affirm the trial court's grant of defendant's motion for summary disposition regarding plaintiffs' claimed antitrust violations. The Antitrust Reform Act prohibits a contract, combination or conspiracy between two or more persons in restraint of, or to monopolize, trade or commerce. MCL 445.772; MSA 28.70(2). However, this act does not apply if a health care corporation engages in the challenged transaction to reduce the cost of health care and the transaction is approved by the commissioner. MCL 445.774(6); MSA 28.70(4)(6). Although the insurance commissioner did not approve the plan at the time that this suit was filed, the commissioner did not reject the plan either. Because defendant did create Premier Plus with the intent of reducing the cost of health care and the plan was permitted by the insurance commissioner, the trial court did not err when it dismissed plaintiffs' antitrust claim.[2]

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[2] The Insurance Commissioner approved the plan on March 19, 1992.

Furthermore, we find that the trial court could have dismissed plaintiffs' antitrust claim under another statutory exclusion. The Antitrust Reform Act states, in relevant part:

> (4) This act shall not apply to a transaction or conduct specifically authorized under the laws of this state or the United States, or specifically authorized under laws, rules, regulations, or orders administered, promulgated, or issued by a regulatory agency, board, or officer acting under the statutory authority of this state or the United States. [MCL 445.774(4); MSA 28.70(4)(4)].

Because defendant was authorized to enter into prudent purchaser agreements by state law, MCL 550.51 *et seq*; MSA 24.650 *et seq*, Premier Plus did not violate the Antitrust Reform Act.

Fourth, plaintiffs maintain that the trial court erred when it granted summary disposition on their breach of contract claim. A trial court may only grant summary disposition on a breach of contract claim if the terms of the contract are not subject to two or more reasonable interpretations. *SSC v Detroit Retirement System,* 192 Mich App 360, 363; 480 NW2d 275 (1991).

We find that the terms of the contract are subject to two or more reasonable interpretations. Plaintiffs allege that defendant breached its physician participation agreements when Premier Plus enacted a three-dollar blood processing fee payable to physicians who use panel laboratories but not payable to those physicians who use non-panel laboratories. Previously, physicians performing their own blood processing and those that used any laboratory for blood processing were entitled to the three-dollar fee. Defendant argues that the physician participation agreements only state that health care providers will be reimbursed for covered services. According to defendant, Premier Plus merely changes the types of services which are covered. Plaintiffs

maintain that, rather than changing the covered services, Premier Plus modified the reimbursement schedule in the physician participation agreement. The trial court agreed with defendant, stating that Premier Plus changed the covered services and not the reimbursement schedule.

Although we acknowledge that this is a possible interpretation of the contract, we find that the terms of the physician's contract could be subject to another reasonable interpretation. Defendant's physician participation agreement states that "for each covered service performed, BCBSM will pay the lesser of billed charges or the published maximum screen as set forth in BCBSM's Maximum Payment Schedule." The description of Premier Plus issued by Blue Cross states, under "Types of Services Covered" that "[t]he range of laboratory services eligible for reimbursement from BCBSM will be the same under this program as they are under the existing laboratory benefit package." Rather than eliminate payments to non-selected laboratories from coverage, Premier Plus uses financial incentives to encourage physicians to use the selected laboratories. Therefore, the determination that physicians would not receive the three-dollar blood processing fee could be construed as a modification of the reimbursement schedule rather than a change in covered services. Because more than one reasonable interpretation of the physician participation contract exists, we find that the trial court erred when it granted defendant's motion for summary disposition on the claim of breach of the physician participation contract.[3]

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[3] Although there is no explicit claim on this basis in the initial complaint, plaintiffs now allege that defendant breached its laboratory participation agreements to reimburse for covered services when it determined that Premier Plus authorized full reimbursement for panel laboratories while only authorizing fifty percent reimbursement for the use of a non-panel laboratory. Unlike the physician participation agreements, this contract provides that defendant can

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Fifth, the trial court determined that plaintiffs had a private cause of action under the Prudent Purchaser Act. MCL 550.51 *et seq;* MSA 24.650 *et.seq.* Unlike Act 350, which states that the Attorney General or the Insurance Commissioner may file suit to enforce that act, and that any person may bring an action in the Ingham Circuit Court to compel the commissioner to enforce the act, the PPA does not expressly authorize any enforcement action. The trial court determined that the absence of any enforcement provision indicated that a private party could sue in equity to enforce the provisions of the PPA. We hold that the trial court erred when it determined that plaintiffs could maintain an action directly against the health care corporation to enforce the provisions of the PPA.

Statutes which share a common purpose are *in pari materia* and must be read together as one law. *Jennings v Southwood*, 446 Mich 125, 137; 521 NW2D 230 (1994). Act 350 contains the authorization for defendant to enter into prudent purchaser agreements. MCL 550.1502a; MSA 24.660(502a). The PPA also states that an organization which provides or administers health care benefits or coverage under a prudent purchaser agreement shall remain subject to all of the provisions of its enabling act. MCL 550.58; MSA 24.650(58). Because each statute has language incorporating the other statute, we read these statutes *in pari materia*. Applying the restrictions on enforcement in Act 350 to the PPA, only the Attorney General and the Insurance Commissioner are entitled to enforce the PPA by a direct action against the health care corporation. Therefore, we hold that the trial court erred when it determined that plaintiffs had a private right of action directly against the health care corporation under the PPA. The relief plaintiffs sought and obtained from the

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change the reimbursement policies as it wishes as long as it provides sixty days written notice to the provider laboratories.

Wayne Circuit Court — a ruling that the PPA applied and an order enjoining implementation of the plan pending compliance with PPA — is available through the procedure set forth in MCL 550.1619(3). Plaintiffs are still free to file an action in the Ingham Circuit Court to compel the commissioner to enforce the act.

IV

In summary, we hold that plaintiffs' claims are not pre-empted by ERISA. We affirm the trial court's grant of summary disposition dismissing plaintiffs' Act 350 claim, their claim of tortious interference with a business relationship, and their claim of a violation of the Michigan Antitrust Reform Act. MCL 445.772; MSA 28.70(2). We reverse the grant of summary disposition on plaintiffs' breach of contract claim because more than one reasonable interpretation of the physician participation contract could exist. We also reverse the trial court's grant of mandamus ordering defendant to comply with the PPA because the PPA does not authorize a private right of action directly against the health care corporation.[4] MCL 550.51 *et seq;* MSA 24.650 *et seq.*

Affirmed in part and reversed in part. We remand for proceedings consistent with this opinion. We do not retain jurisdiction.

/s/ Martin M. Doctoroff
/s/ Michael J. Kelly
/s/ Helene N. White

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[4] While Judge White expressed a contrary view in her earlier opinion, 206 Mich App 585,590 (1994), she is now convinced that the actions to compel compliance with the PPA should have been brought in the Ingham Circuit Court and should have been pleaded as actions to compel the Insurance Commissioner to enforce the act.

Appendix C

MICHIGAN SUPREME COURT
LANSING, MICHIGAN

ORDER
Entered: June 30, 1995

100889
100890
100891

BPS CLINICAL LABORATORIES, MICHIGAN CLINICAL LABORATORY, MML, INC., MBL LABORATORIES, FLINT MEDICAL LABORATORY, ALLIED MEDICAL LABORATORY-FLINT, INC., WILLIAM E. BLAMEY, D.O., MID-MICHIGAN PATHOLOGY SERVICES, P.C., and UNIVERSAL STANDARD MEDICAL LABORATORIES, INC.,
Plaintiffs-Appellees, Cross-Appellants,

v.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN,
Defendant-Appellant, Cross-Appellee.

SC: 100889, 100890, 100891

BPS CLINICAL LABORATORIES, MICHIGAN CLINICAL LABORATORY, MML, INC., MBL LABORATORIES, FLINT MEDICAL LABORATORY, ALLIED MEDICAL LABORATORY-FLINT, INC., WILLIAM E. BLAMEY, D.O., MID-MICHIGAN PATHOLOGY SERVICES, P.C., and UNIVERSAL STANDARD MEDICAL LABORATORIES, INC.,
Plaintiffs-Appellants, Cross-Appellees,

v.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN,
Defendant-Appellee, Cross-Appellant.

LC: 91-107952-CK

Appendix C

In lieu of granting leave to appeal, the case is remanded to the Court of Appeals for reconsideration in light of *New York State Conference of Blue Cross & Blue Shield Plans v Travelers Ins Co*, 514 US __; 115 S Ct 1671; 131 L Ed 2d 695 (1995). MCR 7.302(F)(1).

I, CORBIN R. DAVIS, Clerk of the Michigan Supreme Court, certify that the foregoing is a true and complete copy of the order entered at the direction of Court.

/s/ CORBIN R. DAVIS

CORBIN R. DAVIS
CLERK

June 30, 1995

Appendix D

BPS CLINICAL LABORATORIES; Michigan Clinical Laboratory; MML, Inc.; MBL Laboratories; Flint Medical Laboratory; Allied Medical Laboratory — Flint, Inc.; William E. Blamey, D.O. Robert Chatfield, D.O.; Mid-Michigan Pathology Services, P.C.; and Universal Standard Medical Laboratories, Inc., Plaintiffs-Appellants-Cross Appellees,

v.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN,
Defandant-Appellee-Cross Appellant.

AMERICAN HEALTH RESOURCES, INC.,
Plaintiff-Appellant-Cross Appellee,

v.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN,
Defendant-Appellee-Cross Appellant.

BPS CLINICAL LABORATORIES; Michigan Clinical Laboratory; MML, Inc.; MBL Laboratories; Flint Medical Laboratory; Allied Medical Laboratory — Flint, Inc.; William E. Blamey, D.O. Robert Chatfield, D.O.; Mid-Michigan Pathology Services, P.C.; and Universal Standard Medical Laboratories, Inc., Plaintiffs-Appellees,

v.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN,
Defendant-Appellant.

AMERICAN HEALTH RESOURCES, INC.,
Plaintiff-Appellee,

v.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN,
Defendant-Appellant.

Appendix D

AMERICAN HEALTH RESOURCES, INC.,
Plaintiff-Appellee,

v.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN,
Defendant-Appellant.

BPS CLINICAL LABORATORIES; Michigan Clinical Laboratory; MML, Inc.; MBL Laboratories; Flint Medical Laboratory; Allied Medical Laboratory — Flint, Inc.; William E. Blamey, D.O. Robert Chatfield, D.O.; Mid-Michigan Pathology Services, P.C.; and Universal Standard Medical Laboratories, Inc., Plaintiffs-Appellees,

v.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN,
Defendant-Appellant.

Docket Nos. 145988, 146035, 151162, 151163, 152010 and 153383.

Court of Appeals of Michigan.

Submitted March 8, 1994, at Detroit.

Decided Sept. 6, 1994, at 9:15 a.m.

Released for Publication Oct. 31, 1994.

Before WHITE, P.J., and MICHAEL J. KELLY and CAPRATHE,* JJ.

MICHAEL J. KELLY, Judge.

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* William J. Caprathe, 18th Judicial Circuit Judge, sitting on Court of Appeals by assignment pursuant to Const. 1963, Art. 6, Sec. 23, as amended 1968.

Appendix D

Plaintiffs, independent clinical laboratories and two physicians, alleged that they wrongfully were denied the opportunity to participate as panel providers in defendant's new health care program, Premier PLUS. On October 9, 1991, the circuit court granted defendant's motion for summary disposition with regard to all issues except plaintiffs' claim under the Prudent Purchaser Act (PPA), M.C.L. § 550.51 *et seq.;* M.S.A. § 24.650(51) *et seq.,* which the court found defendant had violated. The parties each appeal the court's summary disposition decision adverse to it. Defendant also appeals an order of March 18, 1992, enjoining operation of Premier PLUS until defendant filed the criteria for participating in the program with the Insurance Commissioner and reconsidered plaintiffs' applications, and an order of April 9, 1992, denying defendant's motion for security pending appeal. The appeals were consolidated. We affirm the order of April 9, 1992, reverse the order of March 18, 1992, and affirm that part of the October 9, 1991, order dismissing all of plaintiffs' claims except the PPA claim. We reverse the part of the October 9, 1991, order finding defendant in violation of the PPA and order it amended to reflect a grant of summary disposition for defendant in light of defendant's preemption defense under the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1001 *et seq.*

I

Defendant is a nonprofit health care corporation. It administers General Motors Corporation's traditional option coverage program under an "administrative services only" contract, which requires General Motors to pay defendant a fee for administering the program and reimburse defendant for all covered health care charges paid by defendant on behalf of program enrollees. Defendant is not an insurer for General Motors' employees. The

Appendix D

Premier Prudent Laboratory Use Program (Premier PLUS) is a diagnostic laboratory network pilot program developed, marketed, and implemented by defendant. Employees under General Motors' self-funded, traditional option coverage plan were the first group to enroll in the program when, in 1990 and 1991, the Corporation-Union Committee on Health Care Benefits at General Motors evaluated potential pilot programs for laboratory services and approved Premier PLUS. Although defendant developed Premier PLUS in part out of a desire to negotiate contracts with the employee health benefit plans for Ford, Chrysler, AT & T, and Ameritech and planned to use Premier PLUS in its own employee benefit plan, General Motors is apparently the only entity enrolled in the program at this time. The General Motors traditional option coverage program is an "employee benefit plan" for purposes of the ERISA.

Before implementation of the Premier PLUS program, defendant paid all diagnostic laboratories according to a maximum-fee schedule. Health care providers who drew blood and sent the samples to the laboratories for analysis received a $3 blood-handling fee from defendant.

Under the Premier PLUS program, defendant established a panel of six provider laboratories, which agreed to discount the rate charged to defendant for services rendered. Physicians who referred blood specimens to nonpanel laboratories would not receive the $3 blood-handling fee. Nonpanel laboratories themselves would be reimbursed only fifty percent of the maximum payment scheduled. In addition, the new program differentiated between standard and nonstandard laboratory procedures. Physicians who performed nonstandard procedures would be reimbursed fifty percent of the maximum fee scheduled. The range of services eligible for reimbursement under the program, whether in whole or in part, remained the same.

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II

Plaintiffs are health care providers excluded from full reimbursement under Premier PLUS. On March 27, 1991, plaintiffs sued defendant, alleging that Premier PLUS violated the Nonprofit Health Care Corporation Reform Act (Act 350), M.C.L. § 550.1101 *et seq.;* M.S.A. § 24.660(101) *et seq.,* and resulted in a tortious interference in the established business relationship between plaintiffs and referring physicians. Plaintiff doctors also alleged that Premier PLUS constituted a breach of contract with defendant.

Plaintiff American Health Resources, Inc., filed a complaint for mandamus on April 25, 1991, requesting that defendant be ordered to comply with the PPA by allowing it to apply for membership as a panel provider in Premier PLUS. The complaint also alleged an unlawful attempt to establish a monopoly in violation of the Antitrust Reform Act. M.C.L. § 445.771 *et seq.;* M.S.A. § 28.70(1) *et seq.* The two cases were consolidated and assigned to the same circuit court judge.

Defendant removed the cases to the federal district court, arguing that plaintiffs' claims were subject to complete preemption under federal law by the ERISA. The federal court on the basis of the face of the complaints, found that it did not have subject-matter jurisdiction under the ERISA and remanded the case to the circuit court on August 7, 1991. It expressly left open the question whether the ERISA preempted plaintiffs' state law claims.

On August 27, 1991, defendant moved for summary disposition. The circuit court granted the motion on October 9, 1991, except with regard to plaintiffs' claim under the PPA, which the court found defendant had violated. With regard to that claim, the court issued a final order requiring defendant to accept

applications from plaintiffs for participation in Premier PLUS. In addition, the court permitted plaintiffs to reinstate their claim for money damages if defendant refused to accept their applications. It also continued a temporary restraining order issued on August 14, 1991, which permitted plaintiffs to be treated as panel providers in Premier PLUS.

On October 31, 1991, defendant rejected all of plaintiffs' applications. On November 13, 1991, the circuit court continued the temporary restraining order with regard to BPS Clinical Laboratories, Michigan Clinical Laboratories, and Universal Standard Medical Laboratories, Inc.

On December 20, 1991, the circuit court found that defendant had continued to violate the PPA and also had violated the October 9, 1991, order. It issued an additional final order requiring defendant to submit its standards for panel membership to the Insurance Bureau within sixty days and added that it would enjoin operation of Premier PLUS if defendant did not comply. The court once again extended the temporary restraining order.

Subsequently, defendant moved for relief from this order and to stay any further proceedings, arguing that the order was void as an improper modification of the October 9, 1991, order and that, nonetheless, it had complied with the December 20, 1991, order. The court denied the motion on March 18, 1992, finding that defendant had not filed its standards with the Insurance Commissioner before reviewing plaintiffs' applications. The court enjoined operation of Premier PLUS until defendant filed its standards and considered plaintiffs' applications in light of those standards.

Defendant moved for security to protect its interests pending appeal. The circuit court denied the motion in an order dated April 9, 1992.

Appendix D

Concurrent with the circuit court proceedings, the Insurance Commissioner also reviewed allegations that defendant had not complied with statutory regulations in implementing Premier PLUS. Although initially having found that defendant had not violated the law and having noted that the law, as applied to Premier PLUS, was probably preempted under the ERISA, the Insurance Commissioner later issued a notice of opportunity to show compliance, requiring defendant to address claims that it had violated the PPA. On March 19, 1992, the Insurance Commissioner issued a notice of dismissal, finding the defendant had complied with the Insurance Code.

III

Defendant contends that plaintiffs' claims are preempted under federal law by the ERISA. The circuit court refused to consider defendant's argument regarding this issue, apparently under the misconception that it had been resolved against defendant by the federal district court.[1] By not addressing the issue, the trial court effectively decided it against defendant. The issue has been thoroughly briefed on a complete record and presents a question of law. We believe that the public interest will best be served by resolving it. See *Detroit v. Dep't of Social Services*, 197 Mich.App. 146, 158, 494 N.W.2d 805 (1992).

Under § 514(a) of the ERISA, a state law that "relates to" employee benefit plans is preempted by the ERISA, 29 U.S.C. § 1144(a), unless it falls under the "savings clause" of § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A). The phrase "relates to" is broadly defined to preempt state laws that have a

[1] Although the federal district court concluded that "complete preemption" did not apply as a basis for subject-matter jurisdiction, it expressly declined to rule on the separate issue whether the ERISA preempted plaintiffs' state law claims.

connection with or reference to an employee benefit plan, even if the law is not specifically designed to affect such plans or the effect is only indirect. *Ingersoll-Rand Co. v. McClendon,* 498 U.S. 133, 138-192, 111 S.Ct. 478, 482-83, 112 L.Ed2d 474 (1990). "It is not the label placed on a state law claim that determines whether it is preempted, but whether in essence such a claim is for the recovery of an ERISA plan benefit." *Cromwell v. Equicor-Equitable HCA Corp.,* 944 F.2d 1272, 1276 (CA 6, 1991) cert. dis. — U.S. —, 113 S.Ct. 2, 120 L.Ed2d 931 (1992). If applicable, the ERISA preempts state common law in addition to statutory law. *Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987).

In *Teper v. Park West Galleries, Inc.,* 431 Mich. 202, 221, 427 N.W.2d 535 (1988), our Supreme Court held that a state law "relates to" an employee benefit plan and would be preempted by the ERISA if it had the effect of

> (1) altering the level of benefits which would be paid out under a given plan from state to state, (2) altering the terms of the plan such as requirements for eligibility, or (3) subjecting the fiduciaries of a plan to claims other than those provided in the ERISA itself.

In *United Wire, Metal & Machine Health & Welfare Fund v. Morristown Memorial Hosp.,* 995 F.2d 1179, 1193 (CA 3, 1993), the court held that a state law may relate to ERISA plans if its effect, even if indirect, "is to dictate or restrict the choices of ERISA plans with regard to their benefits, structure, reporting and administration, or if allowing states to have such rules would impair the ability of a plan to function simultaneously in a number of states."

Even if a state law claim "relates to" the ERISA, it may nonetheless be exempt from preemption under the "savings

clause" in § 514(b)(2)(A). 29 U.S.C. § 1144(b)(2)(A). This provision exempts from preemption state laws that regulate the business of insurance, banking, or securities. The savings clause is itself limited by the "deemer clause," which provides that states may not treat self-insured ERISA plans as insurers in order to subject them to state insurance regulation. 29 U.S.C. § 1144(b)(2)(B).

[1, 2] Thus, states may regulate companies that insure ERISA plans, but they may not regulate ERISA plans. *Lincoln Mutual Casualty Co. v. Lectron Products, Inc.*, 970 F.2d 206, 210 (CA 6, 1992). A self-funded employee benefit plan is not subject to direct regulation by insurance laws pursuant to the language of the deemer clause. *Auto Club Ins. Ass'n v. Frederick & Herrud, Inc. (After Remand)*, 443 Mich. 358, 382, 505 N.W.2d 820 (1993), quoting *FMC Corp. v. Holliday*, 498 U.S. 52, 61, 111 S.Ct. 403, 409, 112 L.Ed.2d 356 (1990).

[3] In this case, plaintiffs allege that defendant's implementation of Premier PLUS resulted in: (1) a violation of Act 350, because defendant failed to file the plan with the Insurance Commissioner and thereby indicate the criteria for becoming a panel member; (2) a violation of the PPA, because defendant failed to offer plaintiffs an application for participation in Premier PLUS; (3) a violation of the Antitrust Reform Act, because Premier PLUS was designed to exclude competition among independent laboratories and did not fall under the antitrust exception for health maintenance organizations; (4) a breach of contract with referring doctors, because Premier PLUS unilaterally changed the terms of reimbursement for services and blood-handling fees; and (5) a tortious interference with the business relationship between laboratories and referring physicians.

Appendix D

We believe the ERISA preemption clause prohibits plaintiffs' claims because the specific state law provisions that form the basis for those claims "relate to" a self-funded employee health benefit plan and do not constitute regulation of the business of insurance. In *Adnan Varol, M.D., P.C. v. Blue Cross & Blue Shield of Michigan,* 708 F.Supp. 826 (E.D.Mich.1989), several health care providers alleged that the defendant's participation agreement for a pilot health care program violated Act 350 and other state laws. The court held the plaintiffs' state law claims related to an ERISA employee benefit plan and were preempted by the ERISA. There, the plaintiffs challenged the authorization and concurrent review procedures in the program that the defendant administered for General Motors. The court found particularly relevant the fact that the defendant merely was acting as an administrator for a self-funded employee benefit plan agreed to between General Motors and its employees. *Id.* at 832.

Plaintiffs' claims "relate to" an employee health benefit plan under the ERISA. The state insurance regulations that plaintiffs seek to impose on defendant would, if applied, force defendant to alter the way it administers an employee health benefit plan adopted and funded by General Motors. Any finding by a court that changes plaintiffs' standing with Premier PLUS will affect General Motors' distributions under the plan. If defendant is ultimately required to consider and accept plaintiffs as panel providers for Premier PLUS, General Motors' benefit plan will be required to reimburse more providers than it had anticipated. Opening the program to other providers will also weaken the leverage needed to negotiate lower fees with a select group of providers, which is undoubtedly a key reason to adopt such a program in a self-funded plan. See *Stuart Circle Hosp. Corp. v. Aetna Health Management,* 995 F.2d 500 (CA 4, 1993) (holding that a Virginia statute, which prohibited insurance companies

from unreasonably discriminating against providers in establishing preferred provider organizations, related to an employee benefit plan). In addition, because insurance laws vary widely from state to state, applying Michigan law in this case would impair the ability of Premier PLUS to function simultaneously in a number of states for multijurisdictional employers such as General Motors. See *United Wire, supra* at 1193.

The next step in the ERISA preemption analysis is to determine the effect of the savings clause. We believe the state-law provisions that form the basis of plaintiffs' claims do not regulate the business of insurance under the facts of this case because Premier PLUS is at this point solely a program for self-funded employee benefit plans. Plaintiffs' claims for breach of contract, tortious interference, and antitrust violations are clearly not based on laws aimed at insurance regulation. See *Pilot Life, supra* 481 U.S. at 50, 107, S.Ct. at 1554. The claims under Act 350 and the PPA also do not constitute efforts to regulate an insurance plan. Defendant administers General Motors' traditional option health care program, which would incorporate Premier PLUS, under an "administrative services only" contract. This contract requires General Motors to reimburse defendant for all the covered health care charges paid by defendant on behalf of program enrollees and to pay defendant a fee for administering the program. The health plan is self-funded; defendant does not function as an insurer. If plaintiffs were to succeed in this suit, the state laws they invoke would be used essentially to regulate a self-funded ERISA plan, not an insurance plan. Thus, plaintiffs may not invoke the savings clause in § 514(b)(2)(A).

[4] Plaintiffs argue that, despite its role as administrator in this case, defendant is an insurance company subject to regulation. It cannot wear two hats. According to plaintiffs, when General Motors or any similarly situated entity sought an admin-

istrator for its self-funded health benefit plan, it chose a regulated entity and subsequently took the good with the bad in making that choice. We consider such reasoning circuitous and unacceptable. The fact that the administrator of the program is also an insurance company does not automatically trigger the savings clause. Plaintiffs' argument would create a situation analogous to the one that the deemer clause was created to prevent. Preemption should not depend on the arbitrary distinction between programs with administrators that happen to engage in the business of insurance and those with administrators that do nothing but manage self-funded benefit plans. If there is any arbitrary distinction to be identified, it is whether a plan is self-funded or insured. As the United States Supreme Court stated in *Metropolitan Life Ins. Co. v. Massachusetts,* 471 U.S. 724, 747, 105 S.Ct. 2380, 2393, 85 L.Ed.2d 728 (1985):

> We are aware that our decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not. By so doing we merely give life to a distinction created by Congress in the "deemer clause," a distinction Congress is aware of and one it has chosen not to alter.

See also *Stuart Circle, supra* at 504 (quoting the same Supreme Court case though ultimately holding that preemption applied where the sponsor of a preferred provider plan served as an insurer and the state law applied only to insurers).

On this note, plaintiffs also contend that Premier PLUS is subject to state insurance laws because it is not strictly a program for self-funded employee benefit plans. Rather, defendant developed Premier PLUS is an effort not only to satisfy General Motors' desire to cut costs with a preferred provider program but also to attract business from other major corporate employee

benefit plans. However, General Motors' self-funded plan is apparently the only one enrolled in Premier PLUS at this time. Because this record closed while Premier PLUS was purely a program for self-funded employee benefit plans managed by defendant under an administrative services only contract, we find plaintiffs' claims are preempted under the ERISA.

IV

Defendant's final two claims of error are arguably rendered moot by our decision regarding preemption. We have reviewed the claims because we anticipate the parties will seek further appellate review in the Supreme Court.

The trial court did not err in modifying its October 9, 1991, order by entering its December 20, 1991, order. The latter order enforced the terms of the former and did not improperly modify it under MCR 2.614(C). Nor did the trial court err in finding defendant in violation of the December 20, 1991, order when it issued the March 18, 1992, order.

The trial court did not err in denying defendant's motion for security under MCR 3.310(D).[2] Our review of this issue is limited to determining whether the trial court abused its discretion. *Zapalski v. Benton,* 178 Mich.App. 398, 404, 444 N.W.2d 171 (1989). MCR 3.310(D)(1) provides:

> Before granting a preliminary injunction or temporary restraining order, the court may require the applicant to give security, in the amount the court deems proper, for the payment of costs and damages that may be incurred or

[2] Defendant concedes that it was not allowed security under MCR 2.109 because it was seeking such security to protect it from damages rather than to cover its costs and expenses.

suffered by a party who is found to have been wrongfully enjoined or restrained.

MCR 3.310(D)(1) is limited to security for a preliminary injunction or a temporary restraining order. *In re Prichard Estate,* 169 Mich.App. 140, 149, 425 N.W.2d 744 (1988). Neither of these is at issue in this case. Although the orders of October 9, November 13, and December 20, 1991, provided for a continuation of an earlier temporary restraining order, the March 18, 1992, order granted a permanent injunction regarding Premier PLUS as long as defendant refused to comply with the PPA. Moreover, where, as here, a full hearing on the merits was held before the issuance of an injunction, the rationale for requiring security is not applicable. See *Felton v. Wedthoff,* 185 Mich. 72, 80, 151 N.W. 727 (1915). Thus, neither the language nor the purpose of MCR 3.310(D)(1) supports defendant's argument. The trial court did not abuse its discretion in refusing defendant's request for security.

Affirmed in part and reversed in part.

CAPRATHE, J., concurs.

WHITE, Presiding Judge *(concurring in part and dissenting in part).*

I respectfully dissent from the majority's conclusion that plaintiffs' claims are preempted by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1001 *et seq.* While the words "relates to" have been given a broad meaning, the preemption clause does not preempt laws that have only a "tenuous, remote, or peripheral" effect on an ERISA plan. *Shaw*

v. Delta Air Lines, Inc., 463 U.S. 85, 97, 103 S.Ct. 2890, 2900, 77 L.Ed.2d 490 (1983). It has been observed:

> A preemption provision designed to prevent state interference with federal control of ERISA plans does not require the creation of a fully insulated legal world that excludes these plans from regulation of any purely local transaction. [*Rebaldo v. Cuomo*, 749 F.2d 133, 138 (CA 2, 1984).]

Plaintiffs' breach of contract claim is not preempted. Plaintiffs have not sued General Motors or the ERISA plan for breach of contract. Rather, they assert that the action of Blue Cross and Blue Shield of Michigan (BCBSM) in unilaterally changing the provider reimbursement level for certain covered services constitutes a breach of the existing contract. This claim only tangentially relates to the ERISA plan. It does not address the relationship between the plan and its subscribers, but, rather, the prior contractual relationship between BCBSM and the providers. Congress did not intend to preempt a state court's application of general contract law merely because one of the contracting parties also contracts with an ERISA plan that might be affected by the first contract.

Furthermore, although the circuit court granted BCBSM summary disposition with regard to this claim, I believe there were genuine issues of material fact regarding whether BCBSM changed the reimbursement level in violation of the existing agreement, or, as claimed by BCBSM, simply changed the covered services.

Nor are plaintiffs' claims of tortious interference with business relationships preempted. Again, plaintiffs have not sued General Motors or the plan, but, rather, BCBSM. The common law regarding tortious interference, like the law of contracts, is a law of general application that only tangentially affects the

ERISA plan. While it is true that at least one of the actions claimed by plaintiffs to be illegal involves an element of the plan — the plan provision providing that physicians are paid $3 to draw blood if they send the blood to a panel laboratory, but not otherwise — the law that the plan allegedly violates, M.C.L. § 445.162; M.S.A. §14.375(22)[1] is a law of general application. Congress did not intend that ERISA plans be exempted from general regulatory laws, addressing traditional areas of state authority, that do not affect relations between the principal ERISA entities — the employer, the plan, the fiduciary, and the beneficiaries. *Firestone Tire & Rubber Co. v. Neusser,* 810 F.2d 550, 553-556 (CA 6, 1987).

With respeet to the tortious interference claim, I conclude that plaintiffs' claim should not have been dismissed. To establish a prima facie case of tortious interference with a business relationship, plaintiffs must show: (1) the existence of a valid business relationship (not necessarily evidenced by an enforceable contract) or expectancy; (2) knowledge of the relationship or expectancy on the part of the defendant; (3) intentional interference inducing or causing a breach or termination of the relationship or expectancy; and (4) resultant damage. *Bonelli v. Volkswagen of America, Inc.,* 166 Mich.App. 483, 496, 421 N.W.2d 213 (1988). There must be the intentional doing of an act that is wrongful per se or the intentional doing of a lawful act with malice and without legal justification for the purpose of invading the plaintiffs' contractual rights or business relationship. Id. Plaintiffs adequately pleaded a prima facie case, including reference to statutory violations constituting wrongful acts per se,

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[1] While the circuit court determined that this statute was not violated, I believe there was a genuine issue whether BCBSM devised and acted as an intermediary in a plan in which doctors received compensation for sending patient specimens to specified laboratories.

and there was a genuine issue whether BCBSM tortiously interfered with plaintiffs' business relationships.

Additionally, I conclude that plaintiffs' claims under the Prudent Purchaser Act (PPA), M.C.L. § 550.51 *et. seq.;* M.S.A. § 24.650(51) *et seq.*, are not preempted. Assuming for the moment that the PPA "relates to" an employee health benefit plan under the ERISA, the savings clause excepts from the preemption clause laws that regulate insurance. Section 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A). The majority concludes that the state law provisions that form the basis of plaintiffs' claims do not regulate the business of insurance "because Premier PLUS is at this point solely a program for self-funded employee benefit plans." *Ante*, p. 907. The majority explains "[t]he health plan is self-funded; defendant does not function as an insurer. If plaintiffs were to succeed in this suit, the state laws they invoke would be used essentially to regulate a self-funded ERISA plan, not an insurance plan. Thus, plaintiffs may not invoke the savings clause in § 514(b)(2)(A)." *Ante*, p. 907. In response to plaintiffs argument that, notwithstanding BCBSM's role as administrator of the GM program, BCBSM is an insurance company subject to regulation, the majority states "[p]reemption should not depend on the arbitrary distinction between programs with administrators that happen to engage in the business of insurance and those with administrators that do nothing but manage self-funded benefit plans." *Ante*, p. 907.

I conclude that plaintiffs' claims alleging a violation of the PPA seek to enforce laws that regulate insurance, notwithstanding that in the instant case Premier PLUS was implemented as part of a self-funded ERISA plan. BCBSM is regulated under a statute that regulates insurance, M.C.L. § 550.1101 *et seq.;* M.S.A. § 24.660(101) *et seq.* (Act 350), and is regulated under that statute even when it acts only as a plan administrator.

Act 350 permits BCBSM to promulgate plans in accordance with the PPA, and the PPA specifically applies to BCBSM as a "health care corporation" incorporated under Act 350. The PPA also specifically regulates third-party administrators the same as insurers. Under these circumstances, I would hold that the PPA is a law "that regulates insurance."

Nor is the insurance savings clause rendered ineffective by the "deemer clause."[2] Plaintiffs do not seek to have General Motors or the plan deemed to be an insurance company. Rather, plaintiffs challenge the process employed by BCBSM in formulating and implementing the Premier PLUS plan. The distinction between "programs with administrators that happen to engage in the business of insurance and those with administrators that do nothing but manage self-funded benefits plans" is not arbitrary. The Legislature has chosen to regulate BCBSM and, recognizing the economic power wielded by BCBSM and other similar organizations, has determined that it is necessary to regulate the manner in which such organizations, including third-party administrators, formulate prudent purchaser agreements and offer participation in such agreements to health care providers. Congress did not intend that BCBSM's activities, comprehensively regulated under state statute, must go unregulated and unchecked when the activity involved is the formulation, implementation, and administration of an ERISA plan, when these activities would otherwise be regulated if the underlying plan was not an ERISA plan. Rather, Congress intended to defer to the state's regulation of companies, such as BCBSM, that are in the insurance business.

Turning to the question whether plaintiffs have a private cause of action under Act 350 or the PPA, I agree with the circuit

[2] Section 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B).

court that plaintiffs' remedy under Act 350 was to file a complaint with the Insurance Commissioner to compel enforcement of the act. M.C.L. § 550.1619; M.S.A. § 24.660(619). The PPA does not contain a similar restriction, and I conclude that plaintiffs could properly invoke the equity jurisdiction of the circuit court to seek to enjoin implementation of a plan that was not implemented according to the PPA or to obtain other appropriate relief. See *Michigan State Employees Ass'n v. Dep't of Mental Health,* 120 Mich.App. 39, 328 N.W.2d 11 (1982).

With regard to the antitrust claim, while not approved, the plan was apparently "permitted" by the Insurance Commissioner, and accordingly the circuit court did not err in concluding that the antitrust statute[3] did not apply. Should it ultimately be determined that the Insurance Commissioner will not permit the plan, I would allow plaintiffs to reinstate their claim.

Lastly, I agree with the majority's discussion in part IV and its conclusion that the circuit court did not err in entering its December 20, 1991, and March 18, 1992, orders, or in denying BCBSM's motion for security pending appeal.

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[3] M.C.L. § 445.774; M.S.A. § 28.70(4).

Appendix E

AMERICAN HEALTH RESOURCES, INC. d/b/a/ PREFERRED LABORATORIES,
Plaintiff,

v.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN, a nonprofit health care corporation,
Defendant.

No. 91-110914-AW
Hon. Richard C. Kaufman

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FINAL ORDER

At a session of said Court held in the City-County Building, City of Detroit, County of Wayne, Michigan on _____

PRESENT: HON. RICHARD C. KAUFMAN

RICHARD C. KAUFMAN
Circuit Court Judge

The parties having submitted cross-motions for summary disposition and the Court being fully advised in the premises;

Appendix E

IT IS HEREBY ORDERED that judgment of summary disposition shall be and hereby is entered in favor of Defendant, Blue Cross and Blue Shield of Michigan, for the reasons stated on the records on October 3, 1991, except:

1. The Court rules that MCLA 550.51 *et seq.* does apply.

2. The Court finds that the only provision Defendant Blue Cross and Blue Shield of Michigan, has violated is the duty to allow Plaintiff laboratories to apply for the panel and hereby orders Blue Cross and Blue Shield of Michigan to accept applications from Plaintiff laboratories for Premier Plus Provider Panel status and act on the application with all deliberate speed. If Blue Cross and Blue Shield of Michigan does not respond with all deliberate speed or responds negatively, Plaintiffs may seek post-judgment relief.

3. Within one year of entry of this order, Plaintiff may move to reinstate the claim for money damages based upon violation of MCLA 550.51 *et seq.* regarding failure to offer applications.

4. The applications will be provided by Blue Cross and Blue Shield of Michigan to Plaintiff laboratories by October 7, 1991, and Plaintiff laboratories will apply by October 11, 1991.

5. In the BPS Clinical Laboratories, et al, case No. 91-107952-CK, the Temporary Restraining Order will continue until Blue Cross and Blue Shield of Michigan makes a determination on the application.

6. American Health Resources, Inc. d/b/a Preferred Laboratories, case No. 91-119014-AW, will get the same relief as provided in the BPS Clinical Laboratories, et al,

Appendix E

Temporary Restraining Order if Blue Cross and Blue Shield of Michigan has not made a determination on its application on or before November 1, 1991.

IT IS FURTHER ORDERED that this is a Final Order.

RICHARD C. KAUFMAN

Hon. Richard C. Kaufman
Circuit Court Judge

Appendix F

ERISA PREEMPTION PROVISION

29 U.S.C. § 1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

Appendix F

(3) Nothing in this section shall be construed to prohibit use by the Secretary of services or facilities of a State agency as permitted under section 1136 of this title.

(4) Subsection (a) of this section shall not apply to any generally applicable criminal law of a State.

(5)(A) Except as provided in subparagraph (B), subsection (a) of this section shall not apply to the Hawaii Prepaid Health Care Act (Haw.Rev.Stat. §§ 393-1 through 393-51).

(B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) of this section—

(i) any State tax law relating to employee benefit plans, or

(ii) any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date.

(C) Notwithstanding subparagraph (A), parts 1 and 4 of this subtitle, and the preceding sections of this part to the extent they govern matters which are governed by the provisions of such parts 1 and 4, shall supersede the Hawaii Prepaid Health Care Act (as in effect on or after January 14, 1983), but the Secretary may enter into cooperative arrangements under this paragraph and section 1136 of this title with officials of the State of Hawaii to assist them in effectuating the policies of provisions of such Act which are superseded by such parts 1 and 4 and the preceding sections of this part.

Appendix F

(6)(A) Notwithstanding any other provision of this section—

(i) in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured (or which is a multiple employer welfare arrangement subject to an exemption under subparagraph (B)), any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides—

(I) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and

(II) provisions to enforce such standards, and

(ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, in addition to this subchapter, any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this subchapter.

(B) The Secretary may, under regulations which may be prescribed by the Secretary, exempt from subparagraph (A)(ii), individually or by class, multiple employer welfare arrangements which are not fully insured. Any such exemption may be granted with respect to any arrangement or class of arrangements only if such arrangement or each arrangement which is a member of such class meets the requirements of section 1002(1) and section 1003 of this title necessary to be considered an employee welfare benefit plan to which this subchapter applies.

(C) Nothing in subparagraph (A) shall affect the manner or extent to which the provisions of this subchapter apply to an employee welfare benefit plan which is not a multiple employer welfare arrangement and which is a plan, fund, or program participating in, subscribing to, or otherwise using a multiple employer welfare arrangement to fund or administer benefits to such plan's participants and beneficiaries.

(D) For purposes of this paragraph, a multiple employer welfare arrangement shall be considered fully insured only if the terms of the arrangement provide for benefits the amount of all of which the Secretary determines are guaranteed under a contract, or policy of insurance, issued by an insurance company, insurance service, or insurance organization, qualified to conduct business in a State.

(7) Subsection (a) of this section shall not apply to qualified domestic relations orders (within the meaning of section 1056(d)(3)(B)(i) of this title), qualified medical child support orders (within the meaning of section 1169(a)(2)(A) of this title), and the provisions of law referred to in section 1169(a)(2)(B)(ii) of this title to the extent enforced by qualified medical child support orders.

(8) Subsection (a) of this section shall not be construed to preclude any State cause of action—

(A) with respect to which the State exercises its acquired rights under section 1169(b)(3) of this title with respect to a group health plan (as defined in section 1167(1) of this title), or

(B) for recoupment of payment with respect to items or services pursuant to a State plan for medical assistance approved under title XIX of the Social Security Act [42

U.S.C.A. § 1396 et seq.] which would not have been payable if such acquired rights had been executed before payment with respect to such items or services by the group health plan.

(9) For additional provisions relating to group health plans, see section 1191 of this title.

(c) Definitions

For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

(d) Alteration, amendment, modification, invalidation, impairment, or supersedure of any law of United States prohibited

Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 1031 and 1137(b) of this title) or any rule or regulation issued under any such law.

(Pub.L. 93-406, Title I, § 514, Sept. 2, 1974, 88 Stat. 897; Pub.L. 97-473, Title III, §§ 301(a), 302(b), Jan. 14, 1983, 96 Stat. 2611, 2613; Pub.L. 98-397, Title I, § 104(b), Aug. 23, 1984, 98 Stat. 1436.)

Appendix G

MICHIGAN PRUDENT PURCHASER ACT

550.53. Prudent purchaser agreements, authorization, limitation, standards, review of health care quality, performance, and utilization; provider panel

Sec. 3. (1) An organization may enter into prudent purchaser agreements with 1 or more health care providers of a specific service to control health care costs, assure appropriate utilization of health care services, and maintain quality of health care. The organization may limit the number of prudent purchaser agreements entered into pursuant to this section, if the number of such agreements is sufficient to assure reasonable levels of access to health care services for recipients of those services. The number of prudent purchaser agreements authorized by this section which are necessary to assure reasonable levels of access to health care services for recipients shall be determined by the organization. However, the organization shall offer a prudent purchaser agreement, comparable to those agreements with other members of the provider panel, to a health care provider located within a reasonable distance from the recipients of such health care services, if a health care provider is located within that reasonable distance.

(2) An organization shall give interested health care providers located in the geographic area served by the organization an opportunity to apply to the organization for membership on the provider panel.

(3) Prudent purchaser agreements shall be based upon the following written standards which shall be filed by the organization with the commissioner on a form and in a manner that is

uniformly developed and applied by the commissioner before the initial provider panel is formed:

(a) Standards for maintaining quality health care.

(b) Standards for controlling health care costs.

(c) Standards for assuring appropriate utilization of health care services.

(d) Standards for assuring reasonable levels of access to health care services.

(e) Other standards deemed appropriate by the organization.

(4) An organization shall develop and institute procedures which are designed to notify health care providers located in the geographic area served by the organization of the formation of a provider panel. Upon receipt of a request by a health care provider, the organization shall provide the written standards described in subsection (3) to the health care provider.

(5) An organization which enters into prudent purchaser agreements with health care providers under this act shall institute a program for the professional review of the quality of health care, performance of health care personnel, and utilization of services and facilities under a prudent purchaser agreement. At least every 2 years, the organization shall provide for an evaluation of its professional review program by a professionally recognized independent third party.

(6) If 2 or more classes of health care providers may legally provide the same health care service, the organization shall offer each class of health care providers the opportunity to apply to the organization for membership on the provider panel.

(7) Each prudent purchaser agreement shall state that the health care provider may be removed from the provider panel before the expiration of the agreement if the provider does not comply with the requirements of the contract.

(8) Nothing in this act shall preclude a health care provider or health care facility from being a member of more than 1 provider panel.

(9) Provider panels may include health care providers and facilities outside Michigan when necessary to assure reasonable levels of access to health care services under coverage authorized by this act.

(10) At the time coverage authorized by this act is offered to a person, the organization shall give or cause to be given to the person the following information:

(a) The identity of the organization contracting with the provider panel.

(b) The identity of the party sponsoring the coverage including, but not limited to, the employer.

(c) The identity of the collective bargaining agent if the coverage is offered pursuant to a collective bargaining agreement.

(11) If a person who has coverage authorized by this act is entitled to receive a health care service when rendered by a health care provider who is a member of the provider panel, the person shall be entitled to receive the health care service from a health care provider who is not a member of the provider panel for an emergency episode of illness or injury which requires immediate treatment before it can be obtained from a health care provider who is on the provider panel.

Appendix G

(12) Subsections (2) to (11) shall not limit the authority of organizations to limit the number of prudent purchaser agreements.

P.A.1984, No. 233, § 3, Eff. Dec. 20, 1984.

AMENDED PRUDENT PURCHASER ACT

550.53. Prudent purchaser agreements; authorization, limitations, standards, procedures, application period, acceptance or rejection, termination; review of health care quality, performance, and utilization; provider panel; optometric services

Text of section effective October 1, 1997

Sec. 3. (1) An organization may enter into a prudent purchaser agreement with 1 or more health care providers of a specific service to control health care costs, assure appropriate utilization of health care services, and maintain quality of health care. The organization may limit the number of prudent purchaser agreements entered into pursuant to this section if the number of agreements is sufficient to assure reasonable levels of access to health care services for recipients of those services. The number of prudent purchaser agreements authorized by this section that are necessary to assure reasonable levels of access to health care services for recipients shall be determined by the organization. However, the organization shall offer a prudent purchaser agreement, comparable to those agreements with other members of the provider panel, to at least 1 health care provider that provides the applicable health care services and is located within a reasonable distance from the recipients of those health care services, if a health care provider that provides the

applicable health care services is located within that reasonable distance.

(2) An organization shall give all health care providers that provide the applicable health care services and are located in the geographic area served by the organization an opportunity to apply to the organization for membership on the provider panel.

(3) A prudent purchaser agreement shall be based upon the following written standards which shall be filed by the organization with the commissioner on a form and in a manner that is uniformly developed and applied by the commissioner before the initial provider panel is formed:

(a) Standards for maintaining quality health care.

(b) Standards for controlling health care costs.

(c) Standards for assuring appropriate utilization of health care services.

(d) Standards for assuring reasonable levels of access to health care services.

(e) Other standards considered appropriate by the organization.

(4) An organization shall develop and institute procedures that are designed to notify health care providers located in the geographic area served by the organization of the acceptance of applications for a provider panel. The procedures shall include the giving of notice to providers of the service upon request and shall include publication in a newspaper with general circulation in the geographic area served by the organization at least 30 days before the initial provider application period. An organization shall provide for an initial 60-day provider application period during which providers of the service may apply to the organization for

membership on the provider panel. An organization that has entered into a prudent purchaser agreement concerning a particular health care service shall provide, at least once every 4 years, for a 60-day provider application period during which providers of that service may apply to the organization for membership on the provider panel. Notice of this provider application period shall be given to providers of the service upon request and shall be published in a newspaper with general circulation in the geographic area served by the organization at least 30 days before the commencement of the provider application period. The initial 60-day provider application period and procedures and the 4-year 60-day provider application periods and procedures required under this subsection do not apply to organizations whose provider panels are open to application for membership at any time. Upon receipt of a request by a health care provider, the organization shall provide the written standards described in subsection (3) to the health care provider. Within 90 days after the close of a provider application period, or within 30 days following the completion of the applicable physician credentialing process, whichever is later, an organization shall notify an applicant in writing as to whether the applicant has been accepted or rejected for membership on the provider panel. If an applicant has been rejected, the organization shall state in writing the reasons for rejection, citing 1 or more of the standards.

(5) A health care provider whose membership on an organization's provider panel is terminated shall be provided upon request with a written explanation by the organization of the reasons for the termination.

(6) An organization that enters into a prudent purchaser agreement shall institute a program for the professional review of the quality of health care, performance of health care personnel, and utilization of services and facilities under the prudent

purchaser agreement. At least every 2 years, the organization shall provide for an evaluation of its professional review program by a professionally recognized independent third party.

(7) If 2 or more classes of health care providers may legally provide the same health care service, the organization shall offer each class of health care providers the opportunity to apply to the organization for membership on the provider panel.

(8) Each prudent purchaser agreement shall state that the health care provider may be removed from the provider panel before the expiration of the agreement if the provider does not comply with the requirements of the contract.

(9) This act does not preclude a health care provider or health care facility from being a member of more than 1 provider panel.

(10) A provider panel may include health care providers and facilities outside Michigan if necessary to assure reasonable levels of access to health care services under coverage authorized by this act.

(11) When coverage authorized by this act is offered to a person, the organization shall give or cause to be given to the person the following information:

(a) The identity of the organization contracting with the provider panel.

(b) The identity of the party sponsoring the coverage including, but not limited to, the employer.

(c) The identity of the collective bargaining agent if the coverage is offered pursuant to a collective bargaining agreement.

(12) If a person who has coverage authorized by this act is entitled to receive a health care service when rendered by a health

care provider who is a member of the provider panel, the person is entitled to receive the health care service from a health care provider who is not a member of the provider panel for an emergency episode of illness or injury that requires immediate treatment before it can be obtained from a health care provider who is on the provider panel.

(13) Subsections (2) to (12) do not limit the authority of organizations to limit the number of prudent purchaser agreements.

(14) If coverage under a prudent purchaser agreement provides for benefits for services that are within the scope of practice of optometry, this act does not require that coverage or reimbursement be provided for a practice of optometric service unless that service was included in the definition of practice of optometry under section 17401 of the public health code, Act No. 368 of the Public Acts of 1978, being section 333.17401 of the Michigan Compiled Laws, as of May 20, 1992.

Amended by P.A.1994, No. 439, § 1, Eff. March 30, 1995; P.A.1996, No. 518, § 1, Eff. Oct. 1, 1997.

Appendix H

TITLE 24 INSURANCE
CHAPTER 243A. MEDICAL CARE AND HOSPITAL SERVICE NONPROFIT HEALTH CARE CORPORATION REFORM ACT
PART 5.

MSA § 24.660(502a) (1997)

MCL § 550.1502a

§ 24.660(502a). Prudent purchaser agreements; group contracts; options; group contracts under which financial or other advantage realized; applicability of subsection (5); individual contracts; rates; contracts subject to §§ 24.660(504) to 24.660(518); discrimination against class of health care providers; provisions inapplicable to certain contracts or renewals; optometric and chiropractic services.

Sec. 502a. (1) For the purpose of doing business as an organization under the prudent purchaser act, Act No. 233 of the Public Acts of 1984, being sections 550.51 to 550.63 of the Michigan Compiled Laws, a health care corporation may enter into prudent purchaser agreements with health care providers pursuant to this section and Act No. 233 of the Public Acts of 1984.

(2) A health care corporation may offer group contracts under which subscribers shall be required, as a condition of coverage, to obtain services exclusively from health care providers who have entered into prudent purchaser agreements.

(3) An individual who is a member of a group who is offered the option of being a subscriber under a contract pursuant to subsection (2) shall also be offered the option of being a subscriber under a contract pursuant to subsection (4). This

subsection applies only if the group in which the individual is a member has 25 or more members or if the provider panel that is providing the services under the contract is limited by the organization to a specific number pursuant to section 3(1) of Act No. 233 of the Public Acts of 1984, being section 550.53 of the Michigan Compiled Laws.

(4) A health care corporation may offer group contracts under which subscribers who elect to obtain services from health care providers who have entered into prudent purchaser agreements shall realize a financial advantage or other advantage by selecting such providers. Contracts offered pursuant to this subsection shall not, as a condition of coverage, require subscribers to obtain services exclusively from health care providers who have entered into prudent purchaser agreements.

(5) An individual who is a member of a group who is offered the option of being a subscriber under a contract pursuant to subsection (2) or (4) shall also be offered the option of being a subscriber under a contract that:

(a) Does not, as a condition of coverage, require subscribers to obtain services exclusively from health care providers who have entered into prudent purchaser agreements.

(b) Does not give a financial advantage or other advantage to a subscriber who elects to obtain services from health care providers who have entered into prudent purchaser agreements.

(6) Subsection (5) applies only if the group in which the individual is a member has 25 or more members and if the group on December 20, 1984 had health care coverage through the group sponsor.

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(7) A health care corporation may offer individual contracts under which subscribers shall be required, as a condition of coverage, to obtain services exclusively from health care providers who have entered into prudent purchaser agreements. A person to whom such a contract is offered shall also be offered a contract that:

(a) Does not, as a condition of coverage, require subscribers to obtain services exclusively from health care providers who have entered into prudent purchase agreements.

(b) Does not give a financial advantage or other advantage to a subscriber who elects to obtain services from health care providers who have entered into prudent purchaser agreements.

(8) A health care corporation may offer individual contracts under which subscribers who elect to obtain services from health care providers who have entered into prudent purchaser agreements shall realize a financial advantage or other advantage by selecting such providers. Contracts offered pursuant to this subsection shall not, as a condition of coverage, require subscribers to obtain services exclusively from health care providers who have entered into prudent purchaser agreements. A person to whom such a contract is offered shall also be offered a contract that:

(a) Does not, as a condition of coverage, require subscribers to obtain services exclusively from health care providers who have entered into prudent purchaser agreements.

(b) Does not give a financial advantage or other advantage to a subscriber who elects to obtain services from health

care providers who have entered into prudent purchaser agreements.

(9) The rates charged by a corporation for coverage under contracts issued under this section shall not be unreasonably lower than what is necessary to meet the expenses of the corporation for providing this coverage and shall not have an anticompetitive effect or result in predatory pricing in relation to prudent purchaser agreement coverages offered by other organizations.

(10) Contracts entered into under this section shall not be subject to the provisions of sections 504 to 518.

(11) A corporation shall not discriminate against a class of health care providers when entering into prudent purchaser agreements with health care providers for its provider panel. This subsection does not:

(a) Prohibit the formation of a provider panel consisting of single class of providers when a service provided for in the specifications of a purchaser may be legally provided only by a single class of providers.

(b) Prohibit the formation of a provider panel that conforms to the specifications of a purchaser of the coverage authorized by this section so long as the specifications do not exclude any class of health care providers who may legally perform the services included in the coverage.

(c) Require an organization that has uniformly applied the standards filed pursuant to section 3(3) of Act No. 233 of the Public Acts of 1984 to contract with any individual provider.

(12) Nothing in the 1984 amendatory act that added this section applies to any contract that was in existence before December 20, 1984, or the renewal of such contract.

Appendix H

(13) Notwithstanding any other provision of this act, if coverage under a prudent purchaser agreement provides for benefits for services that are within the scope of practice of optometry, a health care corporation is not required to provide benefits or reimburse for a practice of optometric service unless that service was included in the definition of practice of optometry under section 17401 of the public health code, Act No. 368 of the Public Acts of 1978, being section 333.17401 of the Michigan Compiled Laws, as of May 20, 1992.

HISTORY: Act 350, 1980, p 1214; eff April 3, 1981.

Pub Acts 1980, No. 350, § 502a, as added by Pub Acts 1984, No. 230, imd eff July 30, 1984; amended by Pub Acts 1988, No. 283, imd eff July 27, 1988.

Amended by Pub Acts 1994, No. 440, eff 90 days from end of 1994 legislative session.

Appendix I

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

BPS CLINICAL LABORATORIES, MICHIGAN CLINICAL LABORATORY, MML, INC., MBL LABORATORIES, FLINT MEDICAL LABORATORY, ALLIED MEDICAL LABORATORY-FLINT, INC., AND WILLIAM E. BLAMEY, D.O.,
Plaintiffs,

v.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN, a nonprofit health care corporation,
Defendant.

No. 91 CV 71302-DI

HON. AVERN COHN

Alan G. Gilchrist (P-23408) Gail F. McIntyre (P-42959) Attorneys for Plaintiffs Bellamy & Gilchrist, P.C. 2500 Buhl Building Detroit, Michigan 48226 (313) 964-3070	Richard John Mathews (P-35173) Joseph W. Murray (P-33284) Attorneys for Defendant 600 Lafayette East, #2115 Detroit, Michigan 48226 (313) 225-0095

AFFIDAVIT OF DAVID P. MAMUSCIA

STATE OF MICHIGAN)
) ss.
COUNTY OF WAYNE)

Appendix I

David P. Mamuscia states as follows:

1. I have personal knowledge of and am competent to testify to all matters contained in this affidavit.

2. I am the Director of the Auto National Group Underwriting department for Blue Cross and Blue Shield of Michigan ("BCBSM"), and a member in good standing of the American Academy of Actuaries. As part of my duties for BCBSM, I am responsible for cost savings analysis for the General Motors Health Care Program ("GMC plan").

3. In my capacity at BCBSM I performed an analysis of cost savings that would be realized by the GMC plan under the Premier Plus diagnostic laboratory network pilot program.

4. This cost savings analysis demonstrated that in the first year of the Premier Plus program the GMC plan would realize a savings of 4.5 million dollars; that in the second year would realize a savings of 5.6 million dollars; and in the third year would realize a savings of 6.7 million dollars through utilizing the Premier Plus program for GMC enrollees with traditional fee for service coverage. (See Exhibit A to this Affidavit.)

5. The savings analysis is based upon the implementation of the March 1991 description of the Premier Plus program, as agreed to between GMC, the UAW and BCBSM. Furthermore, that the savings presumes implementation on the agreed upon date of April 1, 1991.

6. That those participating ("panel") laboratories in the Premier Plus program would be reimbursed at the full discounted rate contracted between each panel laboratory and BCBSM. Said reimbursement being paid directly from GMC funds administered by BCBSM.

Appendix I

Premier Plus has an incentive for panel labs. Ten percent (10%) of the approved payment amount is "at risk", and subject to recovery if the target of 90% overall panel utilization is not met. Recovered monies are to be returned to GMC at a year end reconciliation.

/s/ DAVID P. MAMUSCIA

David P. Mamuscia

Subscribed and sworn to before me this 2nd day of April, 1991.

/s/ PATRICIA E. LANE

Patricia E. Lane, Notary Public
Wayne County, Michigan
My Commission Expires: 12/23/91